ST. BARTHOLOMEW'S
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EDITORIAL

" A decent physicist is worth more than twenty poets."

A recent article in *The Sunday Times* points out that whereas the above quotation epitomised the attitude of the Russian radicals a hundred years ago, there now appears to be room for doubt in the Soviet mind. A well-known Russian novelist, Ilya Ehrenburg, has, in a series of articles in the Communist youth paper *Komsomolskya Pravda,* raised the question of a rift between the Arts and the Sciences.

In the course of a sharp exchange of views, sparked off by complaints from a " spiritually sensitive " student of the humanities about her insensible engineer husband, in his " Lonely Hearts " column, Mr. Ehrenburg tells the young engineers that Chekov may never have ridden in a motor car, but he has a lot more to say about human behaviour and feeling than Henry Ford.

The existence of a supposed gap between the Arts and the Sciences has been a favourite topic in recent years for the wagging of learned tongues and the exposition of high sounding ideals, but does it really exist ?

The perfect education would be the study of every aspect of mankind. The Arts are, in the broadest sense, the study of Man's culture. Medicine is the study of his biology—physical, mental and social, providing a basis for the better understanding of his culture. To complete the picture, a study of Man's material environment is required, and this is the substance of the pure Sciences.

Each of these broad subdivisions of knowledge is therefore complementary and in no way truely divisible from the others. Of those people fortunate enough to receive Further Education, those with a degree in medical science are in a privileged position. Their course of education has, of necessity, included an introduction to the Arts and the pure Sciences as well as specialist work. The trained medical mind should be able to integrate knowledge from these three fields, together with that gained from general reading and experience in practice, to produce an ever-increasing depth of knowledge and wisdom which in the past has characterised the " family physician."

The same is, to some extent, true of the pure Scientist. It is easier for him to become cut off from the world than it is for the doctor, but assuming that he has enough intelligence to resist this tendency he can integrate his speciality with general reading in the Arts or Medical Sciences.

The Humanist is perhaps the least for-

tunate of all the three specialists, since science of any sort tends to be regarded by him as a discipline not worthy of a place in the rarified atmosphere of his mind.

Something is at last being done to help those who cannot see for themselves the inter-relation between the Arts and the Sciences. Science courses are being run parallel with Arts courses, and scientists are being helped to fathom the mysteries of the Humanities. The " gap " between Science and the Humanities does not exist as a defect of the corpus of knowledge ; it is a defect of the mind !

The man studying the pure Sciences, or worse, Medicine, who says " I am nothing but an ignorant scientist " is a defeatist who has failed to see the light, and takes refuge in stubborn pride in his supposed ignorance. He is not ignorant, he is a fool.

Honour

We would like to congratulate Sir James Paterson Ross on being created a Baronet in the New Year's Honours.

The origin of the word Baronet is obscure. but it first appears in English history in the reign of James I. In May, 1611, James, hard-up as ever in his war against the Irish, decreed " a new dignitie between Barons and Knights "—the Baronetage.

The sale of peerages had long been the practice, but it appears that at this time the market was saturated, and the new position was designed to appeal to a new stratum of society. The fee of £1,095 was then enough to keep thirty fighting men in the field for three years at an average of eightpence per day. James undertook to create only two hundred Baronets, all of whom had to have an income of more than £1,000 per year, and whose paternal grandfathers had to be armigerous.

Eight years later James, still short of money, created the Baronetage of Ireland, comprising " one hundred souls".

At this time, questions of the precedence enjoyed by Baronets were proving troublesome. They had originally taken precedence below the younger sons of Barons, but this caused ill-feeling and the enthusiasm of potential buyers waned. The king, wishing to be " much relieved out of vanities and ambitions of the gentrie " granted the heirs apparent of Baronets the right of Knighthood on coming of age.

In 1624, a further lack of funds caused by the expense of colonising Nova Scotia called into existence the Baronetage of Scotland, the charge being three thousand marks (£166 13s. 4d.). In return, the Baronet received 16,000 acres of land in Nova Scotia and the title of " Baronet of His Hienes Kingdom of Scotland."

During the succeeding years the order became chaotic, many people wrongfully assuming the title.

In 1898 the " Honourable Society of Baronetage " was formed to regulate the affairs of the order, and a Royal Warrant of 1914 established an official roll of Baronets. The title is hereditary, and precedence has been re-established after the younger sons of Barons.

Sir James' name joins those of many famous and illustrious men, not a few of whom have graced the annals of Medical Science.

Matron's Ball

The traditional Annual Ball was again held at the Grosvenor House on the 6th January. The occasion shone with splendour ; the gracious proportions of the Great Room made it difficult to believe that almost 1,000 people were present, and able to dance without the discomfort of overcrowding Nurses resplendent, and their partners (some from among students and staff, many others not so familiar) were able to select their dances from the slow foxtrot to the charlston, played by Sidney Lipton and his Band. Dinner was served by an army of waiters and waitresses who appeared from every corner of the room—and all too soon, at 1 a.m., the night nurses had to leave : 1.30 seemed to follow very quickly—and it was over. It was a splendid evening : there would be much scope for the grape-vine !

One regretted Matron's absence, due to indisposition, and we hope she has made a speedy recovery. Miss Turnoch received the guests, and to her, and to Matron, to the Treasurer and Governors, and not least, to those who invited us, we express our thanks for providing this magnificent occasion.

Harvey Society

With the recent publicity about resistant organisms and the search for new antibiotics, with either greater specificity or a broader spectrum, it was interesting to hear about an equally important approach to the problem of cross infection—namely that of prevention rather than cure. This was organised for us by the Harvey Society, when they arranged a meeting to hear about the work which Dr. Steingold has been doing, and to see a film about hospital sepsis, produced by Johnson and Johnson.

Dr. Steingold had been working on the problem of the spread of infection among patients at St. Andrew's Hospital, Bow. The organisms present in a hospital tend to be resistant to the commonly used therapeutic agents, and so the reduction of cross infection is of obvious importance. In his work he has found that nearly 95 per cent of hospitals in Britain are not well enough equipped to prevent a spread from patient to patient as they ought to be, when we consider our relatively inadequate means of treating these infections. This is a bold statement to make, but in his talk introducing the film he was well able to support such a theory.

We heard how dressing trolleys had to be set up in corridors, and how there was a grossly insufficient number of rooms where patients infected with a resistant organism could be isolated. Dust was, in his view, the main enemy, and he was able to tell us of the special vacuum cleaners which filtered off the dust and expelled clouds of pathogenic organisms in their wake ! His work was clearly well backed with so much practical investigation, that even the patients' soap had been tried as a culture medium.

To lend emphasis to what he had to say, an American film underlined almost every point with alarming force and showed how even the most up-to-date air conditioning system was an excellent device for disseminating the organisms.

There is no doubt that this is one of the great problems for us today, and for those who are going to design hospitals in the future. In Bart's there is an extensive study in progress along these lines at the present, and it is going to be very interesting for us now—having had our attention so clearly focussed on the problem by Dr. Steingold —to see what suggestions can be made to help combat hospital sepsis.

Abernethian Society

At the first meeting of the Lent Session, on January 14th, Lord Mottistone was introduced to the Society, and spoke on the discoveries which he and his partner have recently made in the old Charterhouse. He developed the theme along the lines of an excellent detective story. The old Water Course Parchment provided the basis of much conjecture as to original layout of the Charterhouse. One by one, the findings (many of which were made possible by the extensive damage during the recent war) revealed the plan of the pre-dissolution. Monastery. First, the discovery of the door leading into the cloister, and then a considerable area of paving, firmly established the line along which it formerly ran. This meant that the present chapel could certainly not lie on the site of the original Monastic Chapel, and the discovery of fourteenth century windows in the line of the supposed nave rather confirmed this. Shortly afterwards, when the tower was being restored, a squint was found, presumably directed from the treasury to the site at which the High Altar once stood. It seemed fantastic that this could be so readily confirmed by simply exposing the tomb of Walter de Manny, who founded the Charterhouse in 1371, and was known to have been buried at the foot of the High Altar in 1372. This finding was verified by the seal of Clement VI attached to a Papal Bull known to have been granted to Sir Walter. It seemed even more incredible that it was possible to show that the stones of the original chapel were used in the building of the present hall (by Lord North) by the chance exposure in one of the buttresses of a stone on which the coat of arms of Sir John Popham were sculpted—and it was Sir John who had built a large side-chapel at the south-west corner of the main chapel.

Lord Mottistone concluded this most interesting talk by showing a slide of the amazing work of restoration of the painted chimney piece of the Great Chamber, which is now to be seen once again in all its magnificence. We are indeed fortunate to be able to view again the restored splendour of the old Charterhouse.

Snore Cure

A scientist in Genoa, reports the *Evening News*, has invented a machine which cures

snoring. The sound is picked up and, after being amplified, is played back into the offender's ear.

The snorer either awakens, conscious of the fact that he has been snoring, and can readjust his position, or he hears the noise subconsciously and turns on his side without waking. Might be useful on the wards?

Film

The *Medical World* has produced a film, available free to approved (i.e. medical) audiences, entitled "Enquiry into General Practice."

This film examines the place of General Practice in modern society, and is essentially designed to provoke discussion.

The film will be distributed by the B.M.A. Film Library and Sound Services Limited. Until final arrangements have been made for distribution, all preliminary enquiries for booking should be addressed to the *Medical World*, 56 Russell Square, London, W.C.1.

Medical Electronics

Recent advances in this field have resulted in the development of several new measuring techniques for the clinician and the research worker.

The pneumotachometer measures the speed at which air travels in the trachaea and the volume of air respired at each breath. The airstream is made to pass through a piece of metal gauze, giving a minute change in pressure which is related to the rate of flow. This change is detected by an electronic pressure gauge, and the signal obtained fed into a "black box" which computes and records the volume of air breathed in a given time.

The percentage of CO_2 in the expired air can now be measured by electronic instead of chemical methods with a great saving of time and labour. The method is based on the absorbtion of infra-red light by the CO_2 in a sample of breath.

In polio a feed-back mechanism is possible which measures the extent of the patient's respiratory difficulty and regulates the amount of assistance given by the respirator.

Similarly, a "servo-anaesthetiser" has been developed at the Mayo Clinic. This is worked by the patient's brain. The activity of the patient's brain is measured by electronic methods. Any increase or decrease in activity (corresponding to a decrease or increase in the depth of anaesthesia, respectively) operates a relay which adjusts the rate of administration of the anaesthetic accordingly.

These and many other matters of interest in this sphere of electronics will be discussed at the Third International Conference on Medical Electronics, to be held at Olympia from July 21st to 27th this year.

The conference is designed to cater for the novice in this field as well as the expert, and to promote discussions which, it is hoped, will produce new ideas for development.

An International Scientific Exhibition will be held at Olympia concurrently with the conference.

Further information is obtainable from the Secretary, The Institute of Electrical Engineers, Savoy Place, London, W.C.2.

Vacation Course for Clinical Students

From July 3rd to 23rd, 1960, the University of Hamburg will be host to an international gathering of clinical students attending the eighth International Medical Vacation Course for Clinical Students.

The programme is composed of a wide variety of lectures and demonstrations, designed to give a broad view of the present state of medical research, and is supplemented by visits to hospitals.

Various excursions to places of interest are planned, including one to the island of Heligoland.

Total cost for the course is 210DM, which covers fees, bed, breakfast and lunch, but not dinner, for which an extra 2DM per day should be allowed. Accommodation will be in private houses.

Applications must be in before June 15th, and should be accompanied by a deposit of 25DM. Balance to be paid by June 30th. The deposit is not refundable in the event of cancellation. Applications should be sent to Akademische Auslandstelle Hamburg E.V., Hamburg 13, Schluterstrasse 7, Deutschland.

Public Welfare Foundation Undergraduate Prize Competition

The Council of the College of General Practitioners is happy to announce that the above competition, which has been held each year since 1957, will now become a permanent

activity of the College. The competition is open to any senior medical student in any medical school in the United Kingdom and Eire. Six prizes of £40 each will be awarded to the six most successful candidates.

Applicants are asked to give a case history, with a suitable commentary, of one of more patients whom they have seen in general practice. The patient may, but need not, have been admitted to hospital. The student is required to have seen the patient on three or more occasions in the patient's own home or in the general practitioner's consulting room, and to have been introduced to the patient, in the first place, by the family doctor concerned. In presenting his material, the student should give adequate consideration to both the clinical and social aspects of the patient's problem. He is encouraged to discuss the case thoroughly, before writing it up, with the general practitioner concerned. This presentation should include an adequate and concise summary of the salient features.

The material (approximately 1,500 words) should be written or typed on one side only of quarto paper. Adjudicators will allot marks to each essay on the following basis : clinical presentation, maximum 30 marks ; assessment of the social aspects of the patient's problem, maximum 30 marks ; the candidate's appreciation of the general practitioner's role in diagnosis and management, maximum 30 marks ; comment and summary, maximum 10 marks.

Application forms and further particulars may be obtained from the Dean's Office, or from the Secretary of the College of General Practitioners, 41 Cadogan Gardens, London, S.W.3. The closing date for the competition is May 1st, but applications may be sent in at any time.

Fifty Years Ago

In the middle fifties of the Nineteenth Century the Hospital Staff was graced with names like Lawrence and Paget. The *Journal* in 1910 records the memories of Dr. Bradshaw (Surgeon-Major General A.M.S. and Honorary Physician to the King) who was a student at Bart's at this time. Returning from India many years later he " left the Hospital thinking sadly of the changes of persons and buildings which Time had brought about in a quarter of a century " but many features of life at Bart's seem slow to change. Even then " the approach to the main gate was beset on market days with no small risk." And although " crossing the road called for much quickness and circumspection ", the hazards were different ones in the form of " heavy drays . . . and crowds of horned and frightened beasts driven by the roughest of men."

The names of the " many Gamaliels at whose feet *he* sat absorbing the . . . instruction they were so well qualified to give " have changed ; perhaps the characters of their successors are much the same. There was " Dr. Burrows, the lecturer on medicine, tall, well-favoured, and with excellent delivery ; Patrick Black, the warden of the Residential College, tall and with an air of refinement and culture. West, the lecturer on midwifery, of middle height, fair, and wiskered was facing with manliness a temporary unpopularity."

At the head of the Surgical Staff was " Lawrence, a fine handsome man with large, blue myopic eyes." In contrast to Lawrence, his colleague Paget was " tall, gaunt, grave with black hair closely clinging to a small head, orbits cavernous, in which glowed large dark and thoughtful eyes, an ideal lecturer . . . ".

Perhaps the chief reason for Dr. Bradshaw leaving the Hospital on his return " thinking sadly of the changes " was that when he " went into the wards—' dead ' was the answer to all his inquiries respecting well remembered sisters." (Elsewhere in the same *Journal* is recorded the loss from the Hospital Staff of Sister President, Mary, Harley, Casualty and Radcliffe Wards. The Editor at the time records that " they will all take with them pleasant memories of the times spent ' Round the Fountain '—which is, of course, the Hub of the Universe.")

The article ends with a seriousness characteristic of the age, and we are told that even though " the Hospital of Rahere will . . . lead the way. The career of man in intellectual conquest must ultimately receive a check, for it is not imaginable that a Creator would endow a created being with a brain of such potential force as to be able to surmise even the extent of Omniscient Wisdom."

Pot-Pourri, 1959

Christmas at Bart's has long been characterised by the Ward Shows, and it would be hard to imagine the week before Christmas without the sound of hammering from the path. rooms and late night rehearsals in S.O.P.'s.

All this endeavour builds up to a climax which bursts, sometimes literally, upon the patients after their Christmas dinner. Even if one or two of the shows did have their dress rehearsal on the first ward they visited, most got into gear quickly and, by Boxing Day evening, three shows, the House, the Finalists and the Dressers, had been asked to put on extra performances.

From the plethora of material available, the Pot-Pourri Committee had the unenviable task of welding together a show to be presented to a large and critical audience. The fact that they missed the gold so narrowly was not their fault, but rather that of the House whose show suffered greatly from comparison with that of the previous year, and left little more than a nasty taste in the mouth at the end of what had been a most entertaining evening.

The laurels must undoubtedly go to the Finalists, for a show which was in the best traditions of University revue—slick and clever, with good lyrics, tunes and movements. They proved once again that the basis of a good ward show is some sort of underlying plot to give the whole thing unity, and the idea of transporting the audience to an island holiday camp was most successful. The outstanding numbers in this show were Wendy Roles' " The Hole where the Horse used to be " (in which her inimitable stage presence once again delighted the whole audience), " Aunt Agatha," " The Giant and the Pixie " and " You've got to have cash "—a moving exposition from three young business men.

The House, as already mentioned, were disappointing, but certain numbers reproduced the sparkle which one has come to expect from them. Forbes Abercrombie and Richard Simons gave a very polished rendering of " What a swell party this is " and with Alan Whitworth's " Hairy Fairy," were the best parts of their show. David Wright's " Cinderella " and Nick Roles' " Shrine on the Second Floor " were also good. The House's experiment was a good idea, but pantomime has rigid conventions which are not ideally suited to a ward show.

The evening opened with a chorus by the Dressers, which had a good tune and plenty of movement. They also appeared to enjoy themselves, which always helps ; too many numbers were performed with glum faces. Laugh and a Pot-Pourri audience laughs with you.

Well aimed shots were then directed at female coxes, Mr. Marples, and the hardships of " Travelling Tight " in public transport. " The Great Pretender," in which four Dressers mimed the Stan Freberg classic, was an outstanding example of how well a number can be rehearsed, and " Drosky " was a clever pastiche of well known tunes.

In the Out-Patients' and Clerks' show, the cast distinguished itself in " Sweet Violets," which was well presented and deserved the applause it received. Gwilym Michael established himself as a great " natural " comedian in his inimitable rendering of " Come into the Garden, Maud " and three gentlemen in black mourned their " Late Lamented Uncle," whose morbid anatomy held a lesson for all of us !

In the Midder and Gynae. show, Janice Swallow's " The Lady's not a Tramp " was excellent, and " Devonshire Cream and Cider " (written only at the last minute) showed that you are not too old, even at ninety-seven !

Thanks are due to the three comperes for their heroic efforts in what I always feel is a most difficult rôle, and Mike Barton must be congratulated on producing a show of such high overall standard.

FILM SOCIETY

PROGRAMME FOR THE 1960 SEASON

February 8th. *The Wild One*
February 22nd. *The Sheep has Five Legs.*
March 7th. *The Fiends.*
April 25th. *Strange Incident.*
May 9th. *Odd Man Out.*
May 23rd. *The Seventh Seal.*
June 6th. *East of Eden.*
June 20th. *Passport to Pimlico.*
Performances begin at 8.30 p.m.

(*The Committee reserves the right to change the programme without notice.*)

" Drosky "
(or " Love in
a cold Climate ! ")

" . . . Late lamented
Uncle, in the museum
laid to rest . . . "

Keep the ladies
off the river !

CALENDAR

FEBRUARY

Wed. 10—Soccer *v* Royal Dental Hospital (H) L
Cricket Club Dinner
Sat. 13—On duty : Medical and Surgical Units
Mr. G. H. Ellis
Rugger *v* Old Paulines (A) a.m.
Wed. 17—Soccer *v* St. George's Hospital (H) L
Sat. 20—On duty : Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
Soccer *v* Guy's Hospital (A) L
Rugger *v* Saracens (H)
Mon. 22—Film Society, *The Sheep has Five Legs*
Sat. 27—On duty : Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen
Soccer *v* St. Thomas's Hospital (L)
Rugger *v* Treorchy (A)

MARCH

Sat. 5—On duty : Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine
Rugger *v* Old Haberdashers (A)

Honours

Baronet—Sir James Paterson Ross.
Knight Bachelor—Professor Andrew Monyihan Claye.
C.B.E.—Dr. Leonard Anthony Paul Slinger, O.B.E.
Mr. P. H. Jayes has been elected President of the British Association of Plastic Surgeons.

Changes of Address

DR. E. J. BLACKABY, 45 Loxwood Avenue, Worthing, Sussex.
DR. W. NORMAN-TAYLOR, c/o South Pacific Commission, Boite Postale No. 9, Noumea, New Caledonia.
MR. CYRIL S. C. PRANCE, O.B.E., J.P., K.ST.J., Moorlands, Down Road, Tavistock, Devon.

ANNOUNCEMENTS

Engagements

CHARLTON—PRICE.—The engagement is announced between Dr. Clive Arthur Cyril Charlton and Sheelagh Jennifer Price.
IND—BISHOP.—The engagement is announced between John Edgar Ind and Dorothy Bishop.
MAKIN—COWLEY.—The engagement is announced between Edward James Bolton Makin and Julie Irene Cowley.

Marriage

HUCKSTEP—MACBETH.—On January 2nd, Ronald Lawrie Huckstep, M.D., F.R.C.S. to Margaret Ann Macbeth.

Births

GOODWIN.—On December 5th, to Jean and Dr. Stewart Goodwin, a daughter (Ruth Patricia).
MALPAS.—On December 23rd, to Joyce and Dr. James Malpas, a son (Timothy John), a brother for James.
ROWNTREE.—On December 23rd, to Gwendoline and Dr. Paul Rowntree, a son (Samuel).

Deaths

BURSTAL.—On December 6th, Dr. Edward Worsley Burstal. Qualified 1904.
HARVEY.—On December 23rd, Frank Harvey, F.R.C.S., aged 81. Qualified 1902.
LINDSEY.—On December 20th, Dr. Edward Vaughan Lindsey, aged 83. Qualified 1900.
MARKS.—On December 22nd, Leonard Freeman Marks, M.D., F.B.M.A. Qualified 1896.
MATHER.—On November 3rd, Dr. Edward Alton Mather, aged 71. Qualified 1913.
MILES.—On December 29th, Dr. Peter Miles. Qualified 1902.
WADDELL.—On December 22nd, Dr. Ivan Lindley Waddell. Qualified 1913.
WOOD.—On November 12th, Dr. Percival Wood. Qualified 1897.
YOUNGMAN. On January 3rd, John Gordon Youngman, F.R.C.S.(Edin.), aged 48. Qualified 1935.

Mr. Harold Wilson

Mr. Harold Wilson, senior consulting surgeon to the Hospital, died in Suffolk on November 14th, 1959, shortly before his 79th birthday.

He was born at Deer Park, Carlisle, in 1880, the second child of John and Mary Wilson. As a boy, he looked forward to farming his uncle's land at Silloth, and developed the countryman's interests, which always remained with him. The unexpected birth of a son to his uncle led to his decision to enter medicine. Since his father was dead, it was imperative, for financial reasons, that he qualify as quickly as possible, and he was sent to King Edward's School, Chelmsford, to complete his general education, and entered the Medical College in 1898. He qualified with the diploma of the Conjoint Board in 1903, obtaining the F.R.C.S.(Eng.) in 1905. the M.B., B.S. degree of London University in 1907, and the M.S. degree in 1909. During this time it appears that, in order to help support himself, he frequently coached other candidates for the examinations he was taking himself, and he sometimes also played the violin in the orchestra at the Gaiety Theatre. These activities did not keep him from being one of the outstanding students of his year, since in 1903 he obtained the Matthew Duncan prize, and in 1905 the Brackenbury Scholarship in Surgery and the Willett Medal. In 1906 he was awarded the Luther Holden Research Scholarship.

Following qualification, he was appointed house surgeon to Mr. Harrison Cripps and Mr. Hulbert Waring, and he never lost his admiration for his senior chiefs of those days. He was also intern midwifery assistant and then served first as junior and later as senior demonstrator of anatomy under Dr. Addison. At this time he developed a reputation as an excellent teacher, and one of his proud possessions was an inscribed silver box presented to him by the students in the dissecting room on the occasion of his marriage in 1911. In 1913 he was appointed to the honorary staff of the Hospital as assistant surgeon to Mr. Cozens Bailey ; in 1928 he was made full surgeon, becoming, on his retirement in 1945, consulting surgeon. Outside his own hospital he was, in earlier years, assistant surgeon to both the Royal Cancer Hospital and the Victoria Hospital for Children, and he continued until his retirement to operate at two of the number of Cottage Hospitals with which he had at one time been associated.

During the First World War he served in the R.A.M.C. in France, and at the First London General Hospital at Camberwell, attaining the rank of major. In the Second World War, in the Emergency Medical Service, he was at first surgeon in charge at the St. Bartholomew's Sector Hospital at St. Albans, but after a short period he returned to Smithfield. He and his wife lived in London throughout the war and during the time of the heavy air raids in 1940-41, close by the Hospital. At this period he undertook with his junior colleagues, the treatment of the many casualties which came to the Hospital, mostly during the night.

Harold Wilson was a true general surgeon in the days when this implied covering the whole field of surgery as then practised—with the exclusion only of the work carried on in established special departments of the time, Ear, Nose and Throat, Ophthalmic and Orthopaedic. His diagnostic skill, sound judgment and meticulous technique led to excellent results. In the development of the surgical treatment of peptic ulcer and diseases of the biliary tract he did pioneer work in the hospital ; in the management of rectal carcinomata he undertook not only the radical excision with excellent results, but also in certain cases conservative resections by the sacral route ; fractures were always of interest to him—perhaps because of his association with Sinclair in the treatment of the fractured femur during the 1914-18 war. Urology was an early and lasting interest. In 1905 he was pleading for routine cystoscopy in the investigation of renal and vesical disease ; in a large experience of cases of prostatic enlargement he obtained excellent results performing the Thompson Walker operation ; vesical neoplasms were treated thoroughly by partial cystectomy and ureteric transplantation. In carcinoma of the breast his dissections were carried out with scrupulous care. Sulphonamide and antibiotic therapy were developing in the last years of his surgical career and he never quite accepted them. In this connection, it

is of interest that forty years earlier when he assisted his uncle in general practice, he was known as the "washing hands doctor" because of his habit of washing his hands before and after examining a patient—a habit which at the time occasioned much comment.

As a teacher he was outstanding—his method being based upon great clinical experience and an excellent knowledge of anatomy and surgical pathology. He possessed to an unusual extent the ability to make crystal clear the thought processes which led him to a particular diagnosis or course of action, and this, together with his quiet voice and carefully reasoned arguments, made a deep impression on his students. He was always gentle and encouraging to them, and if his language was strong at times this could never cause any offence and did no more than mildly emphasise a point. His quiet sense of humour added to the enjoyment of his ward rounds. His house surgeons and chief assistants gained much from his example—the thoughtful consideration of evidence which led to his diagnostic ability, the gentle, meticulous technique which produced such excellent results, and the conscientiousness which was an outstanding characteristic. His Ward Sisters were also devoted to him and, as a result, the surgical firm which he headed from 1928 until its disruption in 1939, was a quite outstanding one. While his contribution to teaching within the hospital was a considerable one, he rarely attended medical meetings and his writings were few—only eleven contributions to medical literature made between 1906 and 1921 can be traced. The most important of these was probably his joint editorship of Gask and Wilson's Surgery, to which he contributed the section on the surgery of the urinary and male genital systems.

To one who knew Harold Wilson during the last twenty-five years of his life, he always appeared to be one of the personalities of the Hospital, without ever trying to be so. The extremely thin, erect figure suggested physical frailty ; the country tweeds, gay buttonhole and almost jaunty walk disguised it. His serious expression was softened by kind eyes and a ready smile. He was a quiet, shy man, always gentle in his dealings with others but, at the same time, almost unshakable in his convictions. His hospitality in London, and especially in Suffolk, was enjoyed by many of those who worked with him, and they will retain the memory of the atmosphere of happiness in his home, and of his charming wife, Hester, who contributed so much to it. In the country he obtained a deep satisfaction from his garden. Shooting was his other chief pleasure at this time, and the fact that duck and pheasant were available on his own land more than compensated him for the journey of over 250 miles which he made to get there each weekend for much of the year.

In his youth he had many interests. His upbringing produced a love of the countryside, fishing, shooting and sailing ; other interests were music, dancing and bridge. As the years passed these interests dwindled, and in seeking the explanation of this it must be recalled that he was never physically robust. A longstanding dyspepsia necessitated strict dieting for the greater part of his active life, and he was recurrently ill with severe bronchial infections. Restriction of his activities was no doubt forced upon him by his desire to ensure that what he did undertake was well done. Here perhaps too lies the explanation of the small part he took in committee work, and his infrequent contributions to the literature. The stress of the war, which delayed his retirement for four years, tired him greatly, and he went eagerly to his Suffolk home. Here he had built, twenty years earlier, a delightful house overlooking the Waveney river and the marsh of Haddiscoe, and here, with his wife and daughter, he had spent much of his leisure. Sadly, his plans for retirement were never realised, since his wife died suddenly, leaving him a very lonely man. However, in the period of failing health at the end of his life, the surroundings that he knew so well, the visits of his daughter and grandchildren, and the companionship of his doctor—a devoted old house surgeon—helped him greatly.

A great hospital is not a building ; it is a living institution, changing its membership through the years but always in essence the same. In the long succession of those who have served here, Harold Wilson's place is an honoured one ; in the minds of many of those he guided by precept and example it will remain unique.

Social Anthropology and Medicine

by M. S. LIPSEDGE, B.A.

Folk Medicine

Every culture* has its characteristic medical beliefs and practices, religion and customs, economic affiliations, age-group roles, family prestige, social status and vested interests. Certain aspects of the indigenous cultural framework may conflict with Western concepts of curative medicine and hygiene ; the Western-trained physician with a knowledge of local health habits is more qualified to modify undesirable customs and to introduce his own standards and techniques. As Fraser Brockington has pointed out,[1] " a study of environmental sanitation in New Guinea or of maternal and child health in Malaya, cannot be brought to any useful conclusion without an examination of the socio-anthropological issues which determine the course of events. If it is necessary for the human being to defaecate in a mountain stream in order to avoid the risks of evil spirits gaining possession of his excreta, or if expectant or nursing mothers are deprived of essential foodstuffs because of the social or even magical significance of articles of diet, then inevitably the medical officer cannot avoid a study of the beliefs and customs of his group if he is to hope to take any effective public action."

Different human groups have different traditional theories of disease and causation, and when an individual falls ill his emotional attitudes and those of his associates are intimately related to the theories held. In parts of Burma, where a yellow string is tied round the left wrist to avoid cholera, there is a complex combination of systems of treatment of illness. The two main systems, according to the anthropologist Margaret Mead,[2] revolve around the theory of the " four elements of the body " and their state of equilibrium. Treatment depends on the individual's horoscope, so that two people in the same house diagnosed as having the same kind of imbalance will be treated differently if they were born under different planets. There are, moreover, two opposing systems of treatment, one by medication and one by diet. If the different kinds of medicine fail a spell is diagnosed and a " witch doctor " is called. The Berens River Indians of North America believe that a prolonged illness is the result of being bewitched ; gastric symptoms are interpreted as evidence of incipient cannibalism and the victim is killed.[3]

What is recognised as disease or illness is a matter of what Saunders[4] describes as " cultural prescription " and a given biological condition may or may not be considered an illness depending on the particular cultural group in which it occurs. For example there is one South American tribe in which *pinto* (dyschromic spirochaetosis) is so common that those who have it are regarded as healthy, those who do not as ill.[5] Local ideas as to the aetiology of disease cannot be ignored by the Western physician. They may relate to either physical or spiritual phenomena or a combination of both. In New Mexico a belief in the evil eye coexists with the belief that some disease is due to bad blood ; congenital defects or blemishes are believed to arise from unpleasant emotional experiences of prospective mothers ; ulcers are caused by eating greasy foods ; appendicitis from biting fingernails ; cancer from improper alignment of the spine. Pregnancy requires adherence to many dietary restrictions and a reduction in the amount of water drunk, lest the head of the foetus grow too large for an easy delivery. Pregnant women avoid moonlight while in bed and should there be an eclipse during her pregnancy she takes the prophylactic precaution of hanging some keys on a string around her waist, lest the baby be deformed by the effects of the moon's shadow falling on the mother.[6]

The error of acting as if traditional medicine did not exist and of deriding it before the patient is illustrated by Lebeuf's account[7] of how a nurse in Latin America found a child suffering from severe bronchial pneumonia ; when asked why the sick child had not been taken to the clinic the father replied that the child had been afflicted by the evil eye and

* Culture in this context refers to the common way of life shared by members of a society. It includes the totality of tools, techniques, social institutions, attitudes, beliefs, motivations, goals and values which prevail in a particular group of people. It is thus defined as the more or less standardised behaviour of the members of a society.

everyone knew that the doctors knew nothing about that. Health workers in the same region have frequently found seriously ill children at home; the mothers had diagnosed the cases in folk terms of the evil eye and the evil spirits and knowing that physicians denied such causes they preferred to seek traditional remedies. In the Middle East the placenta must be disposed of in ritual fashion otherwise women do not take advantage of maternity services. The taking of blood specimens was opposed by the rural population of Vietnam and the doctors wrongly assumed that their reluctance was due to fear of pain or of the sight of blood. The operation of the health programme was hindered until ethnologists pointed out that as soon as any component of the human body, such as hair, nails or blood are placed in the hands of another person he assumes control of part of the personality of the donor and thus allows the preparation of philtres or other magical potions, which can be used against his will, his health or his destiny.

Anthropology has modified the impression that the folk medicine of a given people is only a random collection of beliefs and practices. Saunders describes it as constituting " a fairly well organised and fairly consistent theory of medicine. The body of knowledge on which it is based often includes ideas about the nature of man and his relationship with the natural, supernatural and human environments. Folk medicine flourishes because it is a functional and integrated part of the whole culture and because it enables members of cultural groups to meet their health needs, as they define them, in ways that are at lease minimally acceptable." Largely as a result of the anthropologists' concern with primitive medicine, it is now appreciated that different societies have their own characteristic ways of defining and treating disease, that people colour their images of disease with backgrounds of emotion and value, and that ideas and customs in this part of culture are systematically linked to other parts. In many preliterate societies there is a general belief that illness is caused by :—

(1) disobedience of taboos,
(2) the refusal to obey orders given in dreams by ancestors,
(3) The action of a malevolent witch or priest.

Nutrition

The system of attitudes, beliefs and practices surrounding food are deeply entrenched aspects of many cultures. Fixed beliefs in the sphere of food consumption may often be a cause of malnutrition. In certain areas of Tanganyka where cattle did not exist, the people had large numbers of fowls, but would not eat the eggs or give them to their children because they believed that to eat eggs would cause sterility. It must not be supposed that because a particular population knows nothing of our nutritional concepts, that they have no concepts whatever regarding nutrition. In the " native reserve " served by the Pholela Health Centre in the Union of South Africa, eighty per cent of the Zulu tribesmen exhibited the marked stigmata of malnutrition, and evidence of gross nutritional failure in the form of pellagra or kwashiorkor was common. Certain traditions as to which foods were customary contributed to the malnutrition and resulted, for example, in local opposition to attempts to increase milk consumption. Women took no milk at all with obvious harmful results to expectant and lactating mothers. Among the Zulus cattle are connected with veneration of ancestors and by the valued norms of human conduct they symbolise good. Consequently ideas and actions concerned with cattle are charged with strong emotions and habits of milk consumption are hard to change. Milk was excluded from the diet of girls once they had passed puberty, as it was thought that during menstruation or pregnancy women exert an evil influence on cattle. Thus concepts concerning milk were enmeshed in the overall cultural pattern. Cassel[8] relates how analysis of the underlying beliefs indicated that the barrier lay in the link between ancestors and cattle. Anthropologists suggested that if milk coming from cows which did not belong to any member of the tribe or any other related groups could be introduced into the community the barrier would be overcome. " The most practical method of accomplishing this was to make powdered milk available. No secret was made of the fact that this powder was a form of milk, but it was stressed that it did not originate from cows belonging to any of the Zulu people." Milk consumption was significantly increased.

Resistance to Change

Despite growing evidence that Salk vaccine

is safe and effective, about one-third of the pre-school children in the United States have not been immunised. It is clear that much of the paralytic poliomyelitis that occurred in 1958 could have been prevented if more persons, and particularly those in the youngest age groups had been vaccinated. Yet the fact remains that large groups in the population failed to accept immunisation,[9] and it is a matter of considerable interest to public health workers to know why these people behave as they do. Again, fluoridation of water supplies, a practice which seems so well founded to the health worker, is rejected by some urban Western communities. These two illustrations of resistance to change are taken from our own Western society. Resistance to change among preliterate peoples is clearly a far greater obstacle to the health worker, for the local ideas on health form part of a cohesive culture pattern. In an analysis of the interrelation of technical change and culture, Margaret Mead writes : " Where a change may seem to the expert to be merely a better way of feeding cattle or disposing of waste, to the people it may seem to be a rejection of the demands of the gods, or a way of giving their welfare and safety into the hands of the sorcerers. An ' improved ' form of house may also be a house without the proper magical screens to baffle the demons who may enter to make one ill." A Bantu might resist hospitalisation of his family with tuberculosis because it would imply that his daughter who spread the disease was a witch. In Latin America, health and sanitation programmes must take into account certain cultural elements, including categories of cultural data like folk medicine, family organisation and prestige complex as well as specific items of cultural content like " hot and cold " distinctions and concern with the " clean " stomach.

In his investigation into water boiling habits in a Peruvian town, Wellin[10] set out to determine why some housewives had decided to boil contaminated water for drinking and why others had not. He learned that housewives who boiled water did so for different and even contrary reasons. Some boiled water because they were sickly, in accord with local conviction about illness and its relation to a dichotomy between " hot " and " cold " foods. Others did so because they rejected the communities' value system including its cleanliness standards Some began boiling drinking water because the hygiene worker recommended it ; others did so only after a more acceptable authority—the physician, legitimised their departure from prevailing norms of water usage. Some failed to boil drinking water because they did not have available an after-breakfast interval which, by virtue of local circumstance and belief, was the only possible and appropriate time to boil water. Among those who decided not to do so were many whose cultural values precluded acceptance of new and competing health values. In summary it turned out that in order to understand fully the variety of response to the water boiling issue, it was necessary to take into account many sectors of culture, including definitions of health and illness, the organisation of timetables and scheduling of daily chores, mobility aspirations, the prevailing status system and the community's pattern of utilisation of its water resources.

In the field of health practices the anthropologist has observed both rational and irrational attitudes and beneficial and injurious customs. Jecliffe[11] advocates either adoption or integration of local food habits and practices associated with pregnancy and methods of child-rearing where these are not in direct conflict with Western methods and may be beneficial in a particular local background. He suggests for example, that prolongation of breast-feeding into the second year of life may be judged biologically necessary for the growth and survival of infants in many subtropical communities, especially in the tsetse fly belt of equatorial Africa, where cattle cannot be raised. Jecliffe considers that customs and attitudes may be rendered harmless by modification and integration. " Thus if orange and other fruit juices are classified as ' cold ' (*tonda*) in a particular food ideology and because of this cannot be given during the winter months it would seem legitimate to make use of the culturally acceptable and scientifically harmless technique of neutralising the essential adherent ' cold ' of the juice by adding a little honey, which is ' hot ' (*gavan*), if by this means the mother will be more willing to allow the infant to take the ascorbic-acid containing juice. Also, by retaining and integrating or at least not opposing a particular custom which, to the scientific viewpoint, may seem quite immaterial to the child's health, it may be possible to increase the parents' confidence."

Confronted with the problem of changing unhygienic habits it may be possible to work within the existing culture pattern. In certain areas of the Middle East manure cakes are used for fuel. These are placed on the flat roof of the dwelling to dry and, during the drying time, they provide a breeding place for flies. As no other fuel is available, health workers have recommended that the manure cakes be made thinner and thus dry out before the flies have a chance to breed in them. Often it is difficult to inculcate a sense of social responsibility in a group which has no concept of the necessity of group action for individual health benefit. For example, when health workers suggested to the inhabitants of an Arab village that water pollution could be prevented by the construction of an efficient drainage ditch, they were incapable of carrying out the work. It was incomprehensible to them that any one person would dig a ditch for the benefit of so many others. They had no social mechanism for distributing the task among everybody. The whole idea of group action was completely strange to the villagers.

There is also the problem of indigenous practices which are found to be absolutely undesirable when judged by scientific criteria, as, for example, the use of cow dung as a dressing on the umbilicus of the newborn child, or the failure to introduce supplementary foods to an infant until he can walk. In these circumstances, Jecliffe suggests that the correct approach is to " alter by persuasion and demonstration the superiority of Western methods. This may be very difficult, especially in an essentially pragmatic peasant population, when dealing with such long term aspects of child health as the nutritional benefits of different methods of infant feeding. It is usually easier to convince when the results are rapidly and easily demonstrated as, for example, in the superiority of benzyl benzoate emulsion over herbal preparations in the treatment of scabies or the efficacy of penicillin therapy in yaws."

In gaining the confidence of the patient it is useful to have a knowledge of the cultural premises and expectations brought into the clinical relationship by the patient. For example, in India, regardless of what the local curer really believes he must assure the patient and family by saying : " He is going to be alright ; he is going to get well." Perhaps the patient will be dead in half an hour, and perhaps the family also knows this. Nevertheless, the ritual words must be spoken otherwise there is no confidence in the doctor.

Resistance to suggested change may have a variety of causes. This is illustrated by the fact that in certain areas of the Western Pacific where boys are more highly valued than girls, the young wife may be forbidden to breast-feed her baby daughter in case the chance of the birth of a son is thus delayed. In order to use persuasion to the best advantage, the doctor must fully understand the resistances that are likely to arise against his advice, and this he can do best by being conversant with the local culture pattern.

Cultural Psychopathology—the Relation Between Culture and Personality Disorder

Socio-anthropological research has established that the structure of human personality is not a universal constant, but varies from culture to culture. Margaret Mead's study of the behavioural manifestations of the crisis of adolescence in Samoa disproved the assumption that human character is fundamentally similar in every cultural environment. In his paper " The cultural developments of personality," Bateson[12] summarises the conclusions to be drawn from her research: " It had been tacitly assumed that the psychological impact of puberty ' naturally ' caused behaviour to be intense and erratic during the period of adjustment to the new physiological equilibrium. It followed from this assumption that if human character and human physiology were essentially alike the world over, we ought to expect a similar period of maladjustment to occur in all cultures. Margaret Mead showed, however, that this was not true of Samoa, and further, that the smooth, easy adjustment of the Samoan adolescent could be referred to peculiarities of the Samoan family organisation. Whereas in Western cultures family organisation is such that very intense ties are established between the child and one or two adults, in Samoa the ties of affection are slighter and are diffused over a large number of adults and child nurses. The capacity for intense emotional behaviour is, in fact, a variable which depends on cultural milieu." The kinds of formative experience which individuals will have and the ways of responding to them depend in large measure on the culture in which they live. For

example, where loss of a biological parent may be a very severe trauma in a society organised on the basis of the small two generation family, it may be much less severe in societies based on large extended families like the Zadruga of the Balkans, or as in China.

The role of culture in shaping the personality and character of the individual is illustrated by the significant changes in frequency of psychomatic and other psychopathological deviance occurring from one period to another in our own society. This is demonstrated by change in sex distribution of perforated peptic ulcer. According to Wolff,[13] in New York Hospital between 1900 and 1939 the male-female ratio of perforated ulcer cases changed from a ratio of 7:6 to a ratio of 36:3. Perforated peptic ulcer follows a definite type of psychological history and character formation. The ailment has become more significantly a male disorder, and cultural changes in sex roles in the last fifty years have been such as would fit this change in sex distribution. This conclusion is based on observations made in the context of only a sub-cultural change. Bateson suggests that "we would predict that still greater differences in form and frequency of psychomatic deviance ought to occur between basically different cultural milieu."

Recent abnormal psychology has recognised the social anthropologists' suggestion that diagnosis cannot be made without reference to cultural context. A man with what by Western standards is considered paranoid behaviour and ideas, may in another cultural set-up, where almost everybody shares his attitudes, be by no means socially disabled but a normal and even ideal participant of his society. (In the classification of paranoia beliefs are diagnosed as a delusional system because they markedly deviate from customary beliefs.) Slotkin[14] considers that the major contribution of anthropology is the opportunity it offers for reducing the ethnocentricism of the diagnostician. He describes the case of a Menomini Indian who was said by a psychiatrist to be suffering from phobias because he was afraid of snakes and night time. When Slotkin explained to the psychiatrist that to the Menomini all but one species of snake are considered to be evil spirits, and that evil spirits, ghosts and witches come out at night, he changed his diagnosis. The fact that the clinician's ethnocentricism may lead him to a wrong conclusion emphasises the importance of the anthropological contribution to his work when he is dealing with patients from subcultures, other than his own or with people from different cultures.

The diagnostician is confronted with the problem of how to distinguish between some unfamiliar culturally conventional forms of behaviour, such as hearing voices, believing that people are killing one by magic and seeing visions, and symptoms of genuine mental illness. Mead considers that, for example, "Behaviour which would be regarded by our standards as a sign of a highly developed neurosis may be quite conventional in another culture, as in the case of ritual cleanliness. Periods of customary religious fasting and withdrawal from all social intercourse may be very difficult to distinguish from attacks of catatonic schizophrenia." Thus it is necessary to establish criteria for diagnosis in trance and vision experience.

It is important to distinguish the *statistical* sense of "abnormal" and "abnormality" and the sense in which these words are used to describe *pathological* conditions. In our own society it is statistically abnormal to listen to Schönberg's String Quartets, but it is not pathological to do so. Conversely the fact that on the Island of Yap the statistical occurrence of intestinal worms is so high that they are locally considered an integral and essential part of the digestive process does not alter the pathological nature of the condition. The paranoid schizophrenic in Western Europe shows behaviour patterns x and y where x represents behaviour which is clearly pathological in the sense that it is completely opposed to the beliefs and behaviour patterns (i.e. the culture) which is accepted in the community as a whole, and which prior to the illness the patient had accepted; y represents behaviour such as suspicion, which can be found in the community as a whole, and which is not thought of as pathological. Now, the behaviour pattern x is abnormal in both senses. y-behaviour may be statistically abnormal, but is probably not pathologically abnormal. In his study of a remote community the anthropologist may discover behaviour which resembles the behaviour classified as x-behaviour in his own Western community. But the important question is whether it may be validly considered x-behaviour with respect to the primitive community, i.e. taking into account the beliefs and patterns

of behaviour which are accepted in that community and are characteristic of it. The anthropologist may also find behaviour resembling the behaviour classified as *y*-behaviour in his own community. This may not even be statistically abnormal in the community being analysed, and was never pathologically abnormal. The following observation illustrates this distinction between statistical and pathological abnormality. In a public health clinic in Israel, I heard a Yemenite immigrant, who was suffering from severe cataract, refuse to undergo surgical treatment, because he maintained that the real cause of his affliction was an evil spirit. Now a West European who believes in evil spirits is abnormal in both *x* and *y* as defined above. A Yemenite holding the same belief is abnormal in neither sense because his belief is consistent with the generally accepted standards of his cultural milieu. Thus, his behaviour is not abnormal in the statistical sense, because the majority of the members of his society behave like this ; nor is it abnormal in the pathological sense because his cultural frame of reference permits this form of behaviour.

Frequently the anthropologist and the psychiatrist come across the individual who is statistically abnormal in his own society and would be classified as pathologically abnormal in ours. He is, however, culturally acceptable in his own group and may have a social function to perform. Indeed, a new group may have social roles which the neurotic or psychotic can assume satisfactorily in which case he is a conformist. For example, among the Tembu certain types of schizophrenes gain high prestige as shamans. Dr. J. Schosberger, the directing psychiatrist of the government work village for mental patients in Israel, told me of a female patient suffering from active open tuberculosis who was admitted to the special ward for such patients. She suffered from chronic hallucinosis and was actively talking back to the voices intruding on her consciousness. She came from the Hadramauth (the Valley of Death) in the southern part of the Arabian peninsular. She would certainly have passed all diagnostic requirements to graduate as a mushrooming paranoid schizophrenic. To Dr. Schosberger's surprise, as soon as her severe somatic disease improved the husband requested to take her home to their immigrant camp. The husband was told that her bodily health did not militate against probation leave, or even discharge, but how would he manage the hallucinations and the fact that she always seemed to be talking to herself. To this he replied that such a contingency was not at all unusual—she just knew how to talk to spirits, and had always done so.

Slotkin has investigated the Menomini Indians of Wisconsin, and summarises the contribution of anthropology to abnormal psychology as follows : " Many fundamental psychopathological concepts implicitly depend upon social or cultural notions. Almost invariably these notions have been derived from the theoreticians' own cultural milieu and may be inadequate when applied to psychiatric disorders found in other societies." Thus tests and diagnostic criteria may have to be reformulated for a particular culture.

While it is still not possible to say that a given culture is less conducive to mental health than another, because of our lack of cross-cultural criteria for mental disorders, it is possible to say that under situations of stress and strain, of rapid change and consequent disorientation, there is likely to be an increase of mental ill health. In heterogeneous cultures, as an individual shifts from one culture to another, or when an immigrant enters a new cultural environment, personality tends to become disorganised. Slotkin concludes that in this situation " psychodynamic generalisations are needed which have universal validity from a comparative (cross-cultural) point of view." Israel has a population which includes a proportion of over fifty per cent of newly arrived immigrants from North Africa and the Middle East. These immigrants find themselves confronted with Western cultural standards and the social implications of modern industrial civilisation. This unprecedented situation provides a unique opportunity for the study of acculturation. I propose to investigate the results of these ethnic group contacts and the process of integration of widely disparate elements from the point of view of " medical anthropology " outlined in this article.

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A G. P. Reports

by L. S. CASTLEDEN

WASP STINGS

Our country practice has been bedevilled by wasps this year of 1959. The splendid weather has favoured a rapid build-up of strong colonies. Last year's great growth of hedgerow weeds has given them shelter.

In the car I carry a small tin of a D.D.T. preparation and a teaspoon on a stick. It is surprising how many wasps' nests can be eliminated in this way. The greatest triumph was when an old lady complained of buzzing in the head. The senile buzzings were not treatable, but the background noise of a lively wasps' nest outside the window was soon removed.

An accurate estimate of the number of consultations for wasp sting is not easily made. Most are enquiries over the telephone, or in the street, and treatment is not necessary. However, the partners here probably actually saw 50 cases and advised a further 50 cases over the telephone.

Most people react locally to wasp stings. The normal course of events is as follows :— The actual insertion of the sting is followed by burning pain. Usually the sting is withdrawn. If, however, the wasp is squashed, the toxin absorbtion is markedly greater, and the sting may be retained. A white area forms around the puncture and swelling of a greater or lesser degree follows. In my experience such swelling continues to increase for 48 hours, and then subsides over the next 24 hours. It is accompanied by itching, and the swelling is of a pink or even a dusky colour. Naturally, a sting near the eye, lip, feet or genitals will swell most. Where the skin is thick, as on the palms and soles, less toxin is absorbed, and the reaction is therefore less. A sting on the tongue or in the throat can be alarming, and even cause respiratory obstruction.

A small proportion of people experience abnormal reactions in the form of a generalised urticaria and an extreme case resembles anaphylactic shock. As some people exhibit nervous shock as well, the clinical picture can be varied. Two of the more severe cases illustrate this :—

Case One

An urgent call to a housewife of 49 years, was received at 1.30 p.m. The history was that seven days before she had put her hand on a wasp. This had produced no marked general reaction. At about 12.30 p.m. she had brushed a wasp off her face which had stung her on the brow. She remembered feeling "suffocated" and going to the door of her cottage, where she must have fainted. At 1.15 p.m. she crawled across to the public house nearby, and the landlord sent for me.

When seen at 1.30 p.m. she was cyanosed and her extremities were cold. The pulse rate was 100 per minute, regular and of fair volume. She was hyperventilating and exhibited marked tremors of the limbs. There was no actual asthma or urticaria or swelling of the air passages. There was a good deal of apprehension, and she kept panting and fainting.

It was suspected that a large proportion of her symptoms were due to hysterical overbreathing following her faint, though it is possible that the original faint was due to the toxin of the sting and the overbreathing was compensatory.

She was propped up on a sofa and warm bottles prepared while adrenalin 1.1000 0.5 cc. was injected subcutaneously, she said that " everything was black," but could recognise who people were by their voices. Repeated comforting words had the hoped-for effect, and she revived steadily. She was also given 100 mgm. mepyramine by mouth, and within three hours was in normal health.

Case Two

A lady of 46 years was stung on both the breast and the ring finger by a Queen wasp which had crept into her brassiere while she was having a bath. There was no history of reaction to previous stings and no past history of asthma, urticaria or hay fever. By the time she had dressed and come downstairs she felt ill. Her head was throbbing, her eyes were red and watery, and the eyelids swollen. A giant urticarial rash was appearing on her arms and legs. She was seen about twenty minutes after the stings, and these appearances were confirmed. It was also noticed that her voice was becoming indistinct and that there was urticarial oedema in the mouth as well as around the eyes. She said also that her breathing was difficult, but no gross asthmatic wheeze or upper respiratory blockage was present.

She was given an injection of 0.5 cc. adrenalin, which checked the reaction, and she was firmly reassured and put to bed.

Every three hours 100 mgm. of " anthisan " (mepyramine) was given. The ring remover was borrowed from the nearest jeweller, and her wedding ring was removed as the oedema of the second sting had caused venous obstruction. Steady recovery followed.

Hornets are not uncommon round here, but I have only seen one authentic case of hornet attack. This was an elderly lady who went blackberrying and did not return. Her daughter went into the wood and heard someone crashing about in the undergrowth. The poor lady was so dreadfully scratched by the briars into which she had rushed when she disturbed the hornets, that it was not possible to even recognise the site of any stings ! The effects were entirely those of fright.

SALMONELLA OUTBREAKS

The Summer of 1959 has been marked by an increase in the number of cases of diarrhoea and sickness. This may well have been accounted for by an increase in the number of flies as well as the fact that food kept less well in the heat.

We had two epidemics of Salmonella typhi-murium, which followed Epizootics on farms.

Series One

A chicken farmer brought his young daughter of nine years to the surgery. She was feverish. Temperature was 101° F. There was quite severe headache but no neck stiffness or local signs. She was a petit mal case on " primidone " so was returned home for observation.

Next day she developed abdominal pain and diarrhoea which was slightly offensive. Flecks of mucus and blood appeared in the stools. She vomited several times. A stool was sent to the laboratory. The illness was quite a serious one. At the end of the first week the appearance was that of typhoid.

Before the result (of the stool analysis) was obtained, her father was also ill with a gastro-enteritis. Both cases were found to be due to Salmonella typhi-murium. Phthalyl sulphathiazole was given to both, and further stools taken from the farmer's wife and the two other children at home. Of the five people in the farmhouse, four were found to be infected, two being symptomless.

Furthermore, the strain of Salmonella suggested a chicken variety. Veterinary help was sought, and specimens collected from various places on the farm. Although the cow and the pigs were evidently free from infection, the source was thought to be the poultry, who can apparently carry certain Salmonellas by which they themselves are unaffected.

The human cases both overt, and carriers were free from the organisms in four weeks.

Series Two

A young farmer of 25 years and his mother aged 60 sought treatment for diarrhoea and abdominal pains. They were both afebrile and ambulant. The following story was obtained.

Ten days before, some calves had arrived from a different county. They were to be weaned to a bucket, and proved difficult. One died with diarrhoea and was buried at once. It was only when the other calves began to scour and become weak with colic and bloody diarrhoea, that the vet was called.

A second calf died while under treatment. By this time the human cases had occurred. Specimens from both the calves, the farmer and his mother grew Salmonella typhi-murium. Milk from the house cow was unaffected.

Unfortunately, the human cases must have passed the infection to the next cottage, where dwelt the farmer's sister, her husband and two children. The children were both quite ill with gastro-enteritis. Salmonella typhi-murium was isolated from the children and one adult.

I daresay that if stools were sent to the pathological laboratory as a routine from all cases of " summer diarrhoea," more cases of spread from farm animals would be discovered. Their prevention can only lie in scrupulous cleanliness by all in contact with animals.

Postscript

The calves mentioned in Series Two proved to be a poor investment from the health point of view.

While feeding them the young farmer was butted in the stomach by one of the calves. This resulted in his collapsing with vomiting and severe pain. His hernial sac had been rammed full by the impact of the calf on his abdomen. A ruptured viscus was also suspected. Operation on the hernia revealed its strangulation as the sole cause of his collapse. As he was still carrying Salmonella typhi-murium, his isolation in hospital was necessary. All ended well.

A CITY PROPOSAL

He asked her the question in quaint old Cloth Fair,
  She replied near the Old Red Cow ;
Then they strolled locked together to Charterhouse Square,
  And solemnly each made a vow.

They found a dark corner in quiet Barley Mow,
  The silence around them was clear :
For they heard nothing else but each other although
  The old market of Smithfield was near.

So they walked up Long Lane onto Aldersgate Street
  And followed the moon towards Cheapside ;
Knowing not where they went on those tireless feet—
  Up Newgate, or down onto Thames side ?

They crossed over Holborn and passed the Old Bailey,
  A loving embrace in its door ;
(But never a thought for the poor folk who daily
  Suffer according to Law).

St. Pauls had dark words as they crossed Ludgate Hill :
  " Take care what you do, my dears " ;
Yet they heard not his warning, but only a thrill
  As wedding bells throbbed in their ears.

Down Blackfriars Lane to catch a tube train,
  Go home with a long explanation :
Of the high cost of rings and of love in the lane,
  Of the loveliest girl in creation.

S. M. WATKINS

Introduction of Radiation Medicine into the Undergraduate Medical Curriculum *

by I. G. Williams

This Report contains the collective views of an international group of experts on the means and methods of introducing the theories and medical applications of ionising radiations into the Undergraduate Medical Curriculum in a more comprehensive and co-ordinated manner than formerly. The following is a summary of the Report.

The world has entered into an Atomic Age, and the student of today will pass his professional life in an era where nuclear power will displace the conventional forms of power. The medical profession is thus brought abruptly face to face with new hazards to health and new potentialities. Furthermore, the science of medicine is incorporating a vast body of knowledge from the applications of radiobiology. It is quite apparent that a passing reference to the effects of ionising radiations will not suffice in the education of the future doctor. The problem facing the educator is that whilst he must go a certain distance to meet the wishes of the specialist, he must preserve the balance of a weighty curriculum and protect the students from demands that may prove detrimental to their intellectual development. In the few short years of medical education, only a small fraction of the vast factual content of medicine can be covered, but the students can and should be helped and encouraged to train themselves in the methodical collection of evidence and in the extraction of warrantable inference from it. The committee reviews the possible means by which the study of radiation medicine and pathology may be integrated with cognate subjects in the future medical course.

The discoveries of recent years in nuclear physics are the most revolutionary developments in thought experienced by our generation. Knowledge of this is widely spread in books and periodicals devoted to the subject, and a general acquaintance with this is a part of the education of any cultured person. The student must, therefore, be provided with knowledge of these new concepts and at least equipped with a foundation of basic theoretical knowledge.

The Preliminary and Preclinical Periods

The groundwork of this particular knowledge is set in the scientific education necessary to achieve (in Britain) the A level examination. All the necessary concepts of radiation physics could be conveyed without recourse to more advanced mathematics. In the secondary schools it is necessacy to present all the divisions of physics with equal stress. In the preclinical medical period the relative emphasis should be changed to biophysics. This altered emphasis has marked educational advantages because of that emotional reinforcement of the learning process to which all educators attach great significance.

Practical experience of the subject matter in any discipline is important. If this cannot be obtained within the limits of the Medical School, co-operation should be sought with those in charge of large University Physics departments. When the pure physics has been covered, the principal applications of radiation in biology and medicine, together with the important aspects of radiation hazards, prevention and protection, can be introduced. During this period in physiology and biochemistry practical examples of the use of isotopes as tools for research in these sciences can be demonstrated. Whilst the advice and supervision of radiation physicists is necessary for protection purposes, every teacher in the preclinical period should endeavour to incorporate tuition in the applications of isotopes, etc., into his own personal teaching, and not depend on some deputising member of the Physics Department. Apart from obvious experiments, such as thyroid function tests, and haemodynamics in physiology, radioautography could help to demonstrate histology, and X-rays including the use of contrast media could be used to demonstrate

* Fifth Report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel. World Health Organisation Technical Report, Series No. 155. 1958. Price 1s. 9d. H.M. Stationery Office.

anatomical facts, as well as physiological processes (such as deglutition).

The Clinical Period

The physical basis for instruction in the clinical period must include an explanation of the units employed to measure the intensities of the various types of irradiation in both physical and biophysical terms, and this can be extended to explain the idea of " dosage." In pharmacology the dose of a drug is that quantity which is required to produce a desired effect. In radiology dose is a product of intensity and time, and, more recently, absorbed energy.

Applications During Various Portions of the Clinical Period

Pathology. At the same time that the students are studying fundamental pathology, they should be instructed in the general features of the tissue and cellular changes that can be brought about by ionising radiations. The local effects of exposure to radiations, the sequelae of whole body irradiation and internal contamination by radioactive substances can be introduced in the study of pathology, but fuller instruction can be left to clinicians and radiologists. The duty of the pathologist is to provide a general conspectus in terms of conventional pathology.

Clinical and Radiological Aspects

As radiations are employed extensively in medicine and surgery both for diagnosis and treatment, it is desirable that a formal organised course of instruction be given to the students under the auspices of the radiological departments. Much of this knowledge should, however, be acquired practically by the student, e.g. through seeing isotopes applied in clinical diagnosis by his teachers in the wards. Instruction must include an account of the risks from excessive radiations, the dangers that the use of isotopes may impose, and the handling of patients who have been exposed to or fear the sequelae of ionising radiations. The hazards of irradiation from the public health aspects should be discussed in the courses in this subject.

The Genetic Effects of Radiations

The subject of possible genetic injuries which may be caused by radiations should come late in the curriculum, when the student has acquired some knowledge of disease states and their aetiology. It could be that some of this teaching could be given by preclinical teachers, providing them with an opportunity for further contact with their former students.

It is apparent that if this general survey of the problem and its possible solutions were to prove acceptable, careful integration is necessary, requiring the close collaboration of all the teachers who take part in it. But as participation in it will be unequally divided, the major responsibility will fall on a senior member of the physics and radiology departments, and these two members must assure a measure of continuity throughout the whole medical curriculum.

The Committee considered, however, that although appropriate formal courses would form the main foundation of this instruction it would be very desirable if in each preclinical or clinical department, the teachers endeavoured to incorporate, through their own personal mastery of the relevant material, the applications of isotopes and radiations into their general scheme of instruction.

Those persons who are interested must study the complete report. The importance of the subject is not in question, and this is true of most specialist subjects. The difficulty is to preserve the balance of the curriculum so as to train a Doctor. Radiation medicine could fit into the medical curriculum in order to give the student a clearer understanding of normal physiological processes and of anatomy. Indirectly and supplemented with specialised instruction the student is kept aware of the use and effects and dangers of ionising radiations.

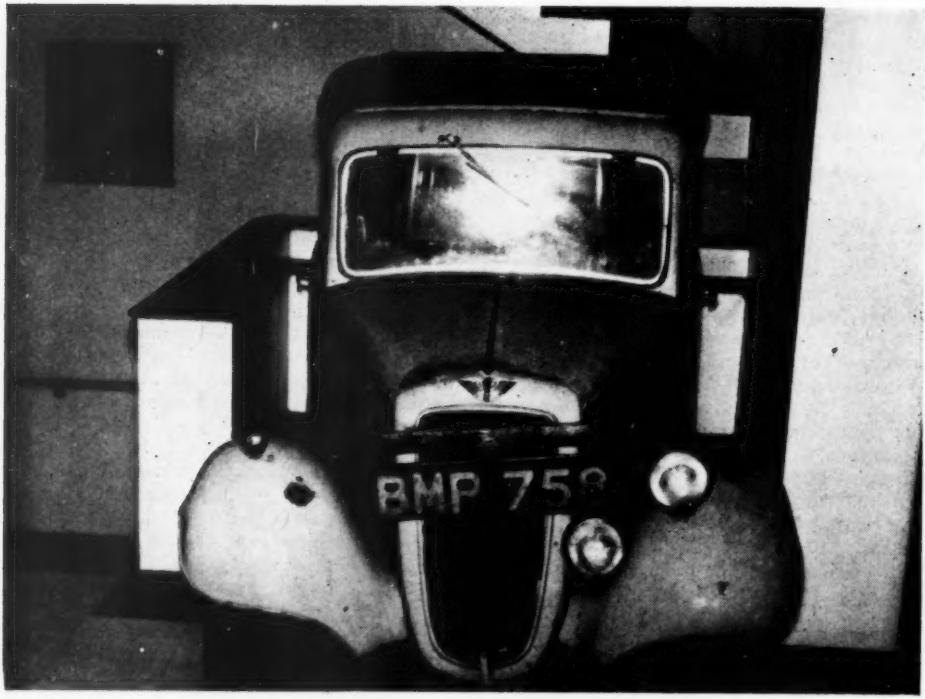
The fact that there is discussion and writing and that conferences are continually being held on medical education indicates some dissatisfaction with the present curriculum. The reasons for this must be either the question of how much of today's knowledge has to be included, or dissatisfaction with ourselves as doctors and the product of the present or immediate past curriculum. Professor Arnott quotes the late Professor Samson Wright as having stated that the ideal medical student must be " tall, handsome, of great personal integrity, beautifully mannered, cultured, highly intelligent, a tireless worker, original, good with his hands, skilfull in exposition, a good mixer, athlete, devoting his spare time to extramural activities, and with a good family background." It is an evident truth that some of

the great advances of medicine in the last 100 years have been made by men whose knowledge of the facts of medicine at qualification were less than those required by the qualifying student today, yet the art and science of medicine and surgery have advanced more in the past 100 years than they did in 1,900 years previously. The teachers of today must sift the knowledge required by the student to those basic facts which must be learnt in order to train an attitude of mind, a mind which can infer, deduce, and reason with the help of these facts—in other words —think. The emphasis must be on subjects which are educationally important. At the same time the student must be exposed to the atmosphere of doctoring—that which can only be taught by example, and which Hippocrates called the Art of Medicine. This is the method of our application of science. No curriculum can contain this nor degree confer it on a student, but by the example of his teachers and slowly by contact with the pain and sickness of humanity he can absorb it.

Science must be included in the curriculum. The normal and abnormal chemistry and physics of the body are basic facts. The inclusion of another branch of knowledge in the students' training can only be justified if it not only increases particular knowledge of the body in health and disease, but provides a means of greater understanding of the patient as a whole, and the education of a receptive mind. This, I believe, a knowledge of ionising radiation will do.

REFERENCE

Brit. Med. Jour. September 5th, 1959. Educational number



Avoiding the Pink Zone?

Examination Results

ROYAL COLLEGE OF SURGEONS

Subject to the approval of the Council of the Royal College of Surgeons, the following Candidates at the examination held in November, 1959, are entitled to the Diploma of Fellow :—

Browse, N. L. Hill, D. W.
Wickham, J. E. A. Williams, D. K.

The following candidates were successful in the Primary Fellowship Examination of the Faculty of Anaesthetists in December, 1959 :—

Jones, H. Davies Paterson, I. S.
Waldron, B. le G.

SOCIETY OF APOTHECARIES OF LONDON

Final Examination, November, 1959

Pathology

Durrant, K. R. Juniper, C. P.

Medicine

Collier, B. R. Durrant, K. R.
Juniper, C. P.

The following Candidate, having completed the Final Examination, is granted the Diploma of the Society :—Juniper, C. P.

Final Examination, December, 1959

The following Candidate, having completed the Final Examination, is granted the Diploma of the Society :—Davies, G.

UNIVERSITY OF LONDON

Special First Examination for Medical Degrees, December, 1959

Kasteliz, B. Kuur, J. B. G.
Pye, C. E. Williams, C. S. J.

The following General Certificate of Education Candidates have qualified for exemption from the First Medical :—

Barretto, J. H. Clements, E. A. F.
Danesh-Haeri, A. A. C. Gilsenan, K. L.
Herbert, T. J. Houghton, A. L.
Lyons, A. J. Milla, P. J.
Morgan, J. C. Ratcliffe, J. F.
Richards, N. C. G. Robb, E. E.
Tompkins, J. C. R.

B.Sc. Special Examination, 1959

Orr, M. M. Second Class Honours (Upper Division).
Shand, D. G. Second Class Honours (Upper Division).
Bootes, J. A. H. Second Class Honours (Lower Division).
Davies, N. M. Second Class Honours (Lower Division).
Hore, B. D. Second Class Honours (Lower Division)
Manchester, K. Second Class Honours (Lower Division).
Perriss, B. W. Second Class Honours (Lower Division).
Brooks, B. G. Boothroyd. Second Class Honours (Lower Division).

UNIVERSITY OF CAMBRIDGE

Examination in Pharmacology, Michaelmas Term, 1959

Pass

Dale, J. W. Stoodley, B. J.

Final M.B. Examination, Michaelmas Term, 1959

Pass

Boston, F. M. Bowles, K. R.
Cantrell, E. G. Church, R. B.
Evans, G. H. Francis, H. B.
Godwin, D. Hamilton, S. G. I.
Hobday, G. R. Lee, B. K.
Maurice-Smith, N. J. Richards, D. A.

Supplementary Pass List

Part I. Pathology and Pharmacology

Bamford, J. K. Clow, E.
Fisher, J. R. H. Garnham, J. R.
Gray, D. J. P. Holland, J. H.
Middleton, B. R. Pennington, J. H.
Scobie, J. D. Seaton, A. T.
Sibson, D. E.

Part II. Medicine

Davies, R. N.

Part II. Midwifery

Davies, R. N.

UNIVERSITY OF OXFORD

Final B.M. Examination, Michaelmas Term, 1959

Medicine

Buckler, J. M. H. Burke, C. W. A.
Cleave, R. L. W.

Surgery

Buckler, J. M. H. Burke, C. W. A.
Cleave, R. L. W.

Midwifery

Buckler, J. M. H. Cleave, R. L. W.
Lyon, D. C.

The following completed the examination for the degree B.M., B.CH. :—

Buckler, J. M. H. Cleave, R. L. W.
Lyon, D. C.

Historical Diagnosis

THE PLAGUE AT ATHENS

Adapted from Thucydides II:49

At first there was an acute inflammation of the head, a redness in the eyes and a burning heat which overcame the victims. As for the inner parts, the throat and tongue became immediately streaked with blood : the patients' breath was most offensive. Also hiccoughing, sore throat and a chesty cough were troublesome. If this became established in the stomach, it upset it, and as many kinds of vomiting as could be named by the doctors took place.

In addition, many suffered from empty hiccoughing, which only produced heavy convulsions.

The outside of the body was neither hot nor particularly pale : it was, however, somewhat red, and livid. Later small boils broke out on it.

The entrails were so hot that the patients could keep no clothing on them, but would gladly have cast themselves into cold water. Their suffering was amplified by restlessness and sleeplessness.

When the disease reached the bowels, an ulceration took place which produced violent diarrhoea ; subsequently many died through exhaustion. Then it hit the privy parts, and many were deprived of these, the tips of their fingers, their toes, and some even lost their eyes.

The survivors suffered from loss of memory, and recognised neither themselves nor their friends and relations.

SMITHFIELD LAMENT

Oh blessed the peace that in Smithfield abounds,
The sight of the lamplighter doing his rounds,
The picturesque buildings, concealed from the view,
Standing so proudly alongside the new.

How grand is the vista we get from the tall
Six storied structure we call College Hall—
The haze over Highgate to stately St. Paul's,
Encompassed by creeper clad, bomb damaged walls.

Alas, how the beauty of Smithfield doth wane,
The skyline is pierced by mechanical crane ;
And Charterhouse, usually tranquil and still,
Is rudely awakened by pneumatic drill.

How brazen the workmen who shatter the dream—
A grindstone protesting with metalline scream,
Whilst pile-driving hammers foundations embed,
Ah well, this is progress, or so it is said !

R. N. W. PRICE

Letter to the Editor

Dear Sir,

The recent letter to the *Journal* discussing the cost of the Rugby Club's West Country Tour was signed "The Spheroids." This has led several people to take this term literally and to jump to the conclusion that the letter was written by members of the Soccer Club. We would like to state that after making enquiries amongst our Club members, we are convinced that no member of the Soccer Club wrote this letter. As regards our Cambridge Tour, this cost around £5 per person for three days. The Club paid £2 to each player and, as we took twelve players, the cost borne by the Student's Union was £24, as the Spheroids stated.

Yours sincerely,
B. D. HORE,
B. W. PERRISS,
D. I. PROSSER.

Abernethian Room,
St. Bartholomew's Hospital.

Sports News

VIEWPOINT

When the present M.C.C. team left for the West Indies a month or two ago, it was noted with some displeasure by certain gossip-cum-cricket columnists that the wives of a number of players were intending to join their husbands at some time during the tour. Evidently it was thought by the critics that their presence would distract the players from the main object of the tour; i.e. playing and winning matches, and lead to a deterioration of their performances on the field.

One wonders if the same type of situation occurs amongst the sportsmen of this Hospital. There have certainly been a number of recent examples in the Cricket Club, where, over the course of a few years, or during one season, a player has completely lost his skill after pursuing other activities of a more serious nature. In other cases, a player with other interests in life finds his free time for sport much curtailed, much to the frustration of club secretaries (though perhaps not of the player concerned). It seems ridiculous that a player, professional or otherwise, should give up one activity for the other. A happy medium seems the best answer to the problem.

Turning to more serious matters, the Rugby Cup match against Charing Cross Hospital was one of the worst seen in recent years, and a draw was a fair result. Our team had some excuse, due to injuries, but it is to be hoped that by the time this is printed, there will have been a return to form.

RUGGER

Bart's *v* **Esher.** Away. Saturday, December 5th. Drawn 6—6

With conditions perfect for a fast open game, the Hospital kicked off against a slight slope, and were very soon pressing the Esher defence. After five minute's play the Hospital were 3 points ahead from a penalty by J. E. Stevens. Esher were soon back on the attack, and scored two very quick tries, and half time came Esher 6, Bart's 3.

In the second half the Hospital were on top all the time, and Stevens levelled the scores with a penalty. The game ended with the Hospital still pressing the Esher defence.

Bart's *v* **Nottingham.** At Chislehurst. Saturday, December 12th. Drawn 6—6.

On a wet windy day, Bart's kicked off against the wind. Although the ball was heavy and greasy, both sides handled well, but neither side could quite finish off any movements, and at half time the scores were level at 0—0.

In the second half, Notts attacked very strongly, and were soon 3 points ahead as a result of a try. The Hospital forwards then took the ball into the opponent's half, and Halls levelled the score with a very good penalty kick. The Hospital now began to attack more strongly and a break by Stevens in the centre sent A. Knox away to score a try, which was unconverted. Near the end of the game Notts scored a try, and the game ended in a draw.

Bart's *v* **Stroud.** At Chislehurst. Saturday, December 19th. Won 11—0.

This match was heralded by rain which made the ball heavy and greasy, however the Hospital handled the ball extremely well and were soon attacking strongly. From a line-out in the Stroud 25, L. R. Thomas made a fine break resulting in a loose scrum being formed in front of the Stroud posts. A quick heel sent the ball to winger Stevens, who gave the final pass on the line for A. Kron to score. The try was unconverted.

Stroud kicked off in the second half, but the Hospital soon forced them back on to their own line. From a scrum in front of the Stroud posts, the Bart's scrum scored a fine pushover try, Stevens adding the extra points. The final score of the match came just before the end, when L. R. Thomas broke on the blind side of the scrum to score just in the corner.

Bart's *v* **Old Rutlishians.** Away. Saturday, January 2nd. Lost 3—9.

The match was played on a very cold wet day and, in the first half, Bart's were the superior side, but they could not take several scoring chances and, at half time, neither side had scored.

In the second half, the Old Rutlishians attacked more strongly, and they opened the scoring with a penalty goal. This completely upset the Hospital's play, and they were a further three points in arrears when the Old Rutlishians dropped a fine goal. The Bart's side then went back on the attack, and A. Letchworth scored a try which G. Halls just failed to convert. From the kick-off the Old Rutlishians forced play into the Bart's 25, and A. P. Ross had to be taken off with an ankle injury. The Old Rutlishians took advantage of this, and just before time scored a good try in the corner to win 9—3.

Bart's *v* **Taunton.** At Taunton. Saturday, January 9th. Lost 6—9.

For the first time for many seasons this game was played in sunshine. In the first half the Hospital were well on top, and deserved to be six points ahead resulting from two penalty goals kicked by J. Stevens.

In the second half Bart's seemed content with a six points lead, and gradually Taunton took command and reduced their arrears with a very good drop goal. The Hospital seemed to wake up somewhat after this, and attacked strongly in the Taunton 25. Taunton, however, soon levelled the score with a good try which resulted from some very poor tackling in midfield. At this point, L. R. Thomas was carried off with concussion. The seven Bart's forwards then played very well and, just at the close, Taunton were awarded a penalty in front of the posts, and the game ended Taunton 9, Bart's 6.

★ ★ ★

1st XV *v* Charing Cross Hospital. At Richmond. Tuesday, January 12th. Hospitals Cup, First Round. Drawn 0—0.

The Oxford Dictionary defines the word "*mascot*" as "person or thing that brings luck." For all the luck that "Percy" brought us against Charing Cross, the beer that was ceremoniously poured over him would have done far more good consumed by a spectator.

The 1st XV, having already fielded a side weakened by injury, suffered a further blow when first R. Davies and then M. Britz were injured. Fortunately Davies returned only, however, to play a very quiet game, as he was still feeling the effects of the very late tackle he received. Bart's were fortunate to draw the match, for Charing Cross should have scored on two or three occasions, especially in the second half, when they won most of the set scrums. Good defensive covering by Bart's, aided by some bad passing and receiving of the ball by Charing Cross, prevented the tries which our supporters were expecting to be scored against us.

The general standard of play was very poor, and Bart's will have to play much better if they are going to do as well as last year. Both the scrummaging and line-outs were very ragged and innumerable passes were knocked-on. Although the forwards exerted great pressure at times, and spent long periods of the first half in the opposing 25, they had little success. It was in this half that the backs hesitated badly when a kick ahead went over our goal line, nearly allowing Charing Cross to score. In the resulting melee, Britz was injured and had to leave the field.

In the second half our forwards were obviously tired, and so the burden of the game came on the defence. The backs tackled well and the forwards, although tired, never allowed themselves to be overwhelmed, despite the fact that they were one short for all but ten minutes of the game.

Apart from a break early in the game by C. Richards, and some runs by Stevens, the backs never seemed likely to score. In the forward line, M. Orr was prominent in the line-outs and G. Halls played an excellent game in the loose, defending and covering very well.

Team : P. Niven, J. Stevens, M. Britz, A. Letchworth, C. Richards, R. R. Davies, A. P. Ross, J. Harvey, M. Jennings, A. Knox, M. Orr, J. Pennington, D. Richards, J. R. L. Jones and G. Halls.

SOCCER

Bart's *v* Caledonians. Saturday, November 21st. Won 2—1.

The Caledonians, a Scottish team drawn from the employees of the Bank of Scotland, found Bart's in a particularly good footballing mood, and were lucky to escape with only two goals against them. Phillips notched our first goal with a fierce drive, but although many chances came our way, the score was still 1—0 at half time. Bart's continued to play good football in the second half; Gould was unlucky to see his fine header hit the bar, but Iregbulum netted from close in. The experiment of playing Hore at centre half seemed to pay off, although he unfortunately put through his own goal to give Caledonians their only score. The forwards, however, missed far too many chances in front of goal, a fault that must be rectified if we are to win matches where only a few scoring chances are presented.

Team : J. Davies, G. Haig, M. Noble, J. Jailler, B. Hore, B. Perriss, P. Savege, H. Phillips, L. Iregbulum, D. Prosser and A. Gould.

United Hospitals League. Barts *v* London Hospital. Wednesday, November 25th. Drawn 2—2.

It must be some time since London Hospital haven't beaten us in a league match, so we may be justifiably satisfied with this result. Yet, with a little bit of luck, we could so easily have won. In the first ten minutes or so, however, Bart's played poor soccer, and our goal was continuously under pressure. During this period London scored their first goal, an angled shot that Davies couldn't quite get to. Somehow Bart's rallied, and during a siege upon the London goal, it was Noble who cracked the ball in after shots by other forwards had been blocked by man or post. Turning round, Bart's played good open football, and took a well-deserved lead when Iregbulum scored with a fine angled shot. However, London immediately equalised following a cross from the right. In the thrilling final minutes both sides came near to scoring, a Bart's effort was kicked off the line while a London shot hit the bar.

Team : J. Davies, G. Haig, F. Amponsah, J. Jailler, B. Hore, B. Perriss, P. Savege, H. Phillips, L. Iregbulum, D. Prosser and M. Noble.

United Hospitals' Soccer Cup, Second Round. Bart's *v* University College Hospital. Saturday, December 12th. Lost 1—4.

Although losing 2—0 to University College Hospital in a league match earlier in the season, we felt reasonably confident of at least drawing this vital match. The team was strengthened by the return of Juniper, while the inclusion of Gould, it was thought, would add spirit to the forward line. But our confidence was shattered before the kick-off, when Gould failed to find the ground. So it fell to ten men to try to hold this tough U.C.H. side. Much rain had made the playing surface slippery, and it is to Bart's credit that U.C.H. were only one goal up at half time. The game was in no way inspiring, being tough and unrelenting, a characteristic of Hospital conflicts. In the second half Jailler had

to move to the right wing because of a recurrence of leg muscle trouble, but his presence was still felt in addition to his verbal encouragement. Bart's goal came after U.C.H. had scored twice more. Iregbulum toying cleverly with the U.C.H. defence, sent a perfect pass to Perriss who, from the left wing position, put the ball into the upper left-hand corner of the net. At this stage Bart's were doing much of the attacking, but hopes of a come-back were dashed when Haig, perhaps unnecessarily, gave away a penalty. The final whistle brought relief to a tired Bart's team, all of whom deserve credit for their performances.

Team : J. Davies, G. Haig, F. Amponsah, J. Jailler, C. Juniper, B. Perriss, P. Savege, H. Phillips, L. Iregbulum and D. Prosser.

LOVE'S LABOURS LOST

Is it any wonder that the god of Love is vexed,
For frankly Piccadilly is becoming over-sexed.
I stand upon my tinny plinth and bow my head in shame,
For love, to Soho's clientele, goes by another name.

The Minister of Works, I fear, would never once suspect
My fervent wish to emigrate to pastures more select.
Regard the luck of Peter Pan in grassy green surrounds,
Far from all the bustle and the traffic's noisy sounds.

Lord Nelson in Trafalgar Square, set high up in the sky,
Beholds my sad predicament, but turns his blinded eye;
Whilst round his feet four lions stand, somnolent with stains,
Where carefree London pigeons misbehaved upon their manes.

With bow in hand, I suffer all the hardships of our clime,
And buses belching Diesel fumes have coated me with grime.
With just my epidermis on, I brave the fiercest storm—
Its high time someone gave a thought to keeping Eros warm!

The only warmth I ever get is when they board me up,
On Guy Fawkes night, St. Patrick's Day, or for the F.A. Cup.
Even in mid-summer when you grouse about the heat,
I'm forced to stand and shiver from the draught down Regent Street!

Its somewhat out of fashion to be shot by Cupid's dart,
For love has turned commercial and has brought the Marriage Mart—
Where lonely hearts complete a form on which they clearly state
Criteria for a future spouse—it makes me so irate!

A mournful amen of these times, that I admit defeat—
The steady march of progress has now made me obsolete,
And thus with heavy, saddened heart I seek your timely aid,
I ask in my retirement, if at Bart's I may be laid.

My humble plea may seem to you to be distinctly odd
But surely there is room at Bart's for yet another "God"!
If in your Square I could reside, romantic charms I'd weave,
For Eros has a trick or two left up his magic sleeve!

Thus in your hands I place my fate and hope for your consent,
And trust that you concur with me, my present role is spent.
Your ancient precincts would afford a fitting place to rest,
So please deter impending doom and heed to my request.

R. N. W. PRICE